The Massachusetts Consumer’s Comprehensive Guide to National Health Reform
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Chapter 1: Introduction and About This Guide

The Patient Protection and Affordable Care Act (ACA) was signed into law by President Obama on March 23, 2010. This health care reform law makes changes across the health care system in the United States with the goal of providing everyone with access to affordable and comprehensive coverage. The national health reform law is in many ways modeled after Massachusetts’s own health reform law passed in 2006, with both including the following key elements:

- Assistance to help make insurance more affordable for low and middle-income individuals;
- The establishment of a Health Insurance Marketplace to help individuals determine if they qualify for help paying for insurance and to help individuals and small businesses more easily compare and enroll in health insurance plans; and
- Provisions to encourage “shared responsibility” among employers and individuals with regard to health insurance coverage. These pieces are also referred to as the “employer responsibility” and the “individual mandate” requirements, respectively.

Because these fundamental components are the same, many of the key achievements of Massachusetts health reform will endure, but there are also some important distinctions between the two laws that will usher in some changes for individuals, employers, insurers, and others in the Commonwealth.

The ACA also included a host of insurance market reforms that are designed to improve health insurance benefits for consumers, and to modify some of the rules regarding how health insurance premiums are priced. Collectively, the changes brought about by the ACA will improve the health insurance coverage landscape in the Commonwealth, building on the strides already made with respect to expanding access to coverage and making it even easier for many individuals, families and small businesses to access more affordable health insurance. However, it is important to note that some of these changes are complex and that while many will see instant improvements, there will be some challenges for others, particularly during the initial transition years.

This guide will provide an overview of major components of national health reform, highlighting areas of intersection with key elements of the state’s health care reform. The primary focus of this guide is on how these laws affect Massachusetts consumers and their health insurance coverage so that Massachusetts consumers, and the employers, advocates, legislators, and others that assist them, continue to be supported and prepared for the implementation of the ACA.

Who This Guide is For and How This Guide is Organized

This guide is intended for Massachusetts residents, advocates, legislators and legislative staff, among others. The guide is organized by certain key elements of state and national health reform and is intended to illustrate and tell the story of how – together – these key pieces will provide easy access to affordable and comprehensive coverage for all residents. While the guide will touch upon several major aspects of the reform, there will be greater attention and detail provided to those areas that will
have the most direct impact on consumers. We have also crafted a guide for employers available at MAhealthconnector.org.

Though every effort is being made to simplify what implementation of national health reform means for consumers, as is the case with change, and particularly change as wide-ranging as this, it is likely that Massachusetts residents may still have questions or need help navigating what all this means for them. To that end, this document concludes with information on the various different entities that are available to provide consumers the assistance and support they need as well as where additional information can be found.

An appendix includes a list of common scenarios and associated responses, which individuals may find helpful as they consider their own circumstances and questions.
Chapter 2: Programs and Policies That Will Help More Residents Get Low or No Cost Health Insurance

As will be discussed in more detail in a later section, both state and national health care reform include an individual mandate, or a requirement for most individuals to obtain health insurance, if affordable health insurance is available to them. This requirement has been in effect in Massachusetts since 2007. The new federal requirement goes into effect as of January 1, 2014. To complement this requirement, both state and national health reform expanded or introduced new programs to help provide low and middle-income people with assistance in accessing no or low cost health insurance options. The expansions or new programs introduced by national health reform mean more Massachusetts residents than ever before will be eligible for MassHealth, the state’s Medicaid program, or will qualify for other help paying for health insurance.

MassHealth Expansion

More people than before will be eligible for insurance through the state’s MassHealth program. Specifically, Massachusetts will expand Medicaid eligibility to all adults aged 21-64 with modified adjusted gross income (MAGI) at or less than 138% of the Federal Poverty Level (FPL) and who are citizens or qualified aliens. This means, for example, if you are single and you earn less than about $15,900 per year, if you are a couple and you earn less than about $21,400 per year, or you are a family of four and you earn less than about $32,500 per year, you may be eligible for no cost health insurance through MassHealth. MassHealth will also be expanding coverage for young adults aged 19 and 20 with incomes up to 150% FPL or about $17,250 per year.

As a result, individuals who were previously eligible for benefits through the Health Connector’s Commonwealth Care program or the Department of Unemployment Assistance’s (DUA) Medical Security Program (MSP) will now be eligible for MassHealth programs. In addition, many individuals who were previously eligible for programs such as MassHealth Basic and MassHealth Essential will now qualify for more comprehensive coverage. MassHealth and the Health Connector are working closely to ensure a smooth transition for those members who will be moving to a new coverage program. In most cases, MassHealth will enroll members in their new benefits behind-the-scenes and members will not have to take any action except if they wish to choose a new health plan. Only MSP members will need to apply to find out if they qualify for the new MassHealth programs.

Individuals who qualify for MassHealth and who are enrolled in or have access to employer-sponsored insurance may be able to receive help paying their premium (known as premium assistance) so they can enroll in the health insurance plan offered by their employer.\(^1\)

**Tax Credits**

Tax credits are available through the Health Connector to help lower the cost of the premium for an individual or family that qualifies. These tax credits are applied to health plans, known as qualified health plans or QHPs, which are purchased through the Marketplace, or the Health

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\(^1\) Please note: an employee’s eligibility for the MassHealth Premium Assistance program will not result in any penalty or financial liability for the employer.
Connector in Massachusetts. To qualify, an individual must:

- **Citizenship**: Be a citizen or a national or non-citizen that is lawfully present
- **Incarceration status**: Not be incarcerated
- **Residency**: Reside or intend to reside in Massachusetts
- **Income**: Have a MAGI of 400% FPL or less. This is about $46,000 per year for an individual or $94,000 per year for a family of four.
- **Government Sponsored Insurance (GSI)**: Not be eligible or enrolled in GSI such as, MassHealth, Medicare, or TRICARE.²
- **Employer Sponsored Insurance (ESI)**: Not be eligible for “affordable” ESI or ESI providing a minimum value or level of coverage. Affordable ESI is defined as a self-only plan that requires the subscriber to pay 9.5% or less of his income toward the health insurance premium for self-only coverage. Minimum value is defined as 60% of the total allowed costs of benefits. A Summary of Benefits Coverage document will help a consumer understand if their plan meets these minimum value standards.

One of the benefits of national health reform is that through these tax credits, low-income people who cannot afford coverage offered through their jobs may qualify for help paying their health insurance premiums. This is an improvement from today, where many of these people are not able to access subsidized coverage.

**Cost Sharing Reductions**

In addition to premium tax credits, national health reform provides cost sharing reductions to individuals with income up to 250% FPL, or about $28,700 for a single person household. Cost sharing reductions help lower the out-of-pocket costs (e.g., co-payments, co-insurance, or deductibles) for eligible enrollees when they, for example, go to a doctor’s appointment, have a hospital stay, or otherwise use health care services. Cost sharing reductions are available to some Health Connector members through ConnectorCare plans.

**ConnectorCare Plans**

Massachusetts will be offering plans known as ConnectorCare plans to individuals with income up to 300% FPL, or about $35,000 for an individual or $71,000 for a family of four. Individuals who qualify for these plans will pay even lower monthly premiums and lower out-of-pocket costs because they are partially paid for by the state. If you qualify for a ConnectorCare plan, you will be able to get the most savings possible.

While some programs are ending, there will be new opportunities to continue to help people in Massachusetts pay for health insurance. As described above, many people currently enrolled in the Health Connector’s Commonwealth Care program will become eligible for MassHealth. In addition, other people enrolled in the Commonwealth Care program will become eligible for ConnectorCare plans, which have a new name, but are designed to provide members with benefits and costs that

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²There are a couple exceptions to this including: for up to three months while an individual or family is completing an application for enrollment in GSI, and until the first day of the first month following the eligibility determination for GSI.
are similar to what they experience today in Commonwealth Care. Specifically, individuals enrolled in ConnectorCare plans will receive federal tax credits and cost sharing reductions, but the state will also help pay for premiums and cost sharing reductions so these plans feel similar to Commonwealth Care.

Similarly, while MassHealth is discontinuing its current Insurance Partnership (IP) program for small businesses and their employees, many individuals who are self-employed or who work for small employers, including former IP members, will qualify for tax credits or ConnectorCare plans through the Health Connector. Those who are not eligible for tax credits due to the ACA’s rules about access to ESI may qualify for continued premium assistance for their employer’s plan through MassHealth.

People currently enrolled in MSP may now qualify either for MassHealth or for help paying for health insurance by shopping through the Health Connector and using tax credits to lower their monthly premium costs. And for many people who do not qualify for help paying for health insurance now, for example, an individual with income between $35,000 and $46,000 or a low income individual who cannot afford their employer’s offer of coverage but who is not able to qualify for other help paying for insurance, these changes present new opportunities for savings.

Health insurance coverage will be effective under these new options beginning in January 2014, but the enrollment process can begin as early as October 2013. The Health Connector, through MAhealthconnector.org, will help you quickly and easily find out which options might work for you. See page 17 for more information on how to determine if you qualify and how to enroll.
Chapter 3: Insurance Market Reforms

In addition to introducing new opportunities to help individuals and families access more affordable health insurance, national health reform introduces a host of new insurance market reforms intended to ensure the insurance plans people are purchasing are providing good benefits and value for their premium dollars. The types of insurance market reforms that were introduced by national health reform are wide-ranging, though they all trace back to the overall goals of the law: to improve access to health insurance, to make health insurance more comprehensive, and to provide supports to individuals and small businesses that can help make coverage more affordable.

Related to these goals, broadly speaking, the insurance market reform provisions that most directly impact consumers fall into four main categories:

- Reforms to help improve access and strengthen protections for consumers;
- Reforms to help promote comprehensive benefits coverage;
- Reforms to promote transparency to help make it easier for consumers to identify what their plan covers and the value they are getting from their insurance plan; and
- Reforms that modify the rules regarding how health insurance is priced for individuals and small businesses.

In order to help make the numerous and diverse insurance market reform provisions of the national health reform law that impact consumers more understandable, we have organized this section of the consumer guide using these categories to help explain relevant insurance market changes.

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While many of the federal health insurance reforms will take effect in 2014, some have been in effect for a number of years. While most of the federal requirements are similar in spirit to state laws and regulations that govern the Massachusetts health insurance market, there are important changes consumers should know about. In summarizing these key provisions, we have made note of their interaction with relevant state regulations, if applicable.
Not all of these provisions apply to all market segments. This means that depending on your coverage source and type, not all of these provisions may apply to the plan you have. For example, there are some differences in the rules depending on whether an individual acquires coverage on his or her own through the Health Connector or directly through a carrier, through a small business (an employer with 50 or fewer employees), or through a large employer. In discussing these provisions, we make note of the markets to which the reforms apply to try and help you determine if they are applicable to the plan you have.

**Reforms to Improve Access and Strengthen Consumer Protections:**

- **Guaranteed Issue:** The national health reform law requires health plans in the individual and small group markets to provide coverage to all eligible individuals beginning in 2014. A health plan cannot deny someone coverage because of a particular illness or condition or because of other risk factors like age or gender. Massachusetts already has requirements like this in place, though the state did insurers to impose certain waiting periods for coverage associated with certain pre-existing conditions, if an individual who did not previously have coverage became enrolled. This is discussed in more detail immediately below.

- **Coverage for Pre-Existing Conditions:** The ACA and Massachusetts law prohibit the use of pre-existing condition exclusions against any individual beginning January 1, 2014 for all individual and small group plans sold or renewed on or after that date.³ This means that being sick will not prevent someone from being able to find coverage. Massachusetts already prohibited health plans from denying health insurance coverage to anyone because of a pre-existing condition; however, the Commonwealth did allow health plans to limit coverage of pre-existing conditions for up to six months for individuals who did not demonstrate continuous health insurance coverage prior to enrollment.

- **Rescission:** Under provisions of Chapter 288 of the Acts of 2010, an individual or small group health plan is not allowed to retroactively drop an insured person or member from a plan, except in case of fraud, intentional misrepresentation of a material fact, or for nonpayment of premiums. Massachusetts already prohibited retroactive cancellations except in certain limited instances, including fraud.

- **Elimination of Waiting Periods of More Than 90 Days:** Beginning in 2014, a group health plan (i.e., a health plan offered by your employer), cannot require an individual to have to wait more than 90 days in order to become eligible for enrollment and coverage in the health plan. Proposed regulations pertaining to the elimination of waiting periods can be found at: [http://www.gpo.gov/fdsys/pkg/FR-2013-03-21/pdf/2013-06454.pdf](http://www.gpo.gov/fdsys/pkg/FR-2013-03-21/pdf/2013-06454.pdf)

³The exception is that grandfathered individual plans are not subject to this requirement under the ACA.
Reforms to Promote Comprehensive Coverage

• **Coverage for Preventive Care:** As of 2010, a health plan\(^4\) is required to cover certain preventive services without cost sharing. Cost sharing includes deductibles, coinsurance, copayments, and similar charges. Cost sharing does not include premiums or balance-billing amounts for non-network providers.

Insurers in Massachusetts had historically been permitted to charge co-pays or other fees for preventive care, so this is a new requirement. Final regulations on the preventive services subject to this ACA provision are available at: [www.healthcare.gov/center/regulations/prevention/regs.html](http://www.healthcare.gov/center/regulations/prevention/regs.html).

• **Coverage for Older Children:** As of 2010, health plans are required to offer coverage for a child on a parent’s health plan until the child reaches the age of 26, regardless of dependent status. A child will qualify for coverage under the federal law even if he or she is married, not living with a parent, is not a dependent on a parent’s tax return, or is no longer a student. In Massachusetts, health plans were already required to allow a child to be covered on a parent’s plan until the child reached age 26. (Under federal law, this requirement now applies to all non-grandfathered plans, including self-insured plans, which had not been subject to the Massachusetts requirement prior to the ACA.)

The ACA does not require that a covered child’s children be offered coverage on a parent’s (grandparent’s) employer-sponsored health insurance plan. However, in Massachusetts, a child of a covered dependent must be offered coverage on the date of birth and thereafter, as long as that child’s parent is a dependent on the grandparent’s plan.

The ACA provides an exception for grandfathered group plans, which allows a grandfathered group plan to deny coverage to an adult child who is eligible for employer-sponsored insurance through his or her own employer.

• **Essential Health Benefits (EHBs):** Beginning in 2014, the ACA requires health plans offered in the individual and small group markets, both inside and outside of the Marketplaces (in Massachusetts, the Health Connector) to offer a comprehensive package of items and services, known as “essential health benefits.” EHBs must include items and services in at least the following 10 categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services (including chronic disease management), and pediatric services (including oral and vision care).

\(^4\)Grandfathered plans are not subject to this requirement under the ACA.
Each state was permitted to select its own “benchmark” plan that would set the framework for what its EHB requirements would entail, within the broad categories required by the ACA. Massachusetts selected HMO Blue 2000 Deductible from Blue Cross and Blue Shield of Massachusetts as its EHB benchmark plan, with supplemental dental coverage for children. For more information, visit: http://www.mass.gov/ocabr/docs/doi/ma-essential-benchmark-plan.pdf

• **Annual Limits Restriction and Prohibition**: By 2014, health plans will not be able to impose an annual limit on coverage of EHB services. Prior to 2014, the ACA allows a phased approach for gradually eliminating annual limits. For plan or policy years that began after September 2010, the plan could not have an annual limit of less than $750,000. For plan or policy years that began after September 2011, an annual limit of less than $1.25 million could not be imposed, by 2012, this increased to $2 million, and as described above, any limits on EHB services are prohibited as of 2014.

Generally speaking, health plans with annual caps do not meet the current Massachusetts’s Minimum Creditable Coverage (MCC) regulations developed under Massachusetts health reform, so this change will not have implications for a large number of Massachusetts residents.

• **Lifetime Limits Prohibition**: Beginning in 2010, a health plan was not allowed to limit the dollar value of the EHBs (described above) that an enrollee can receive in a lifetime.

Most health plans sold in Massachusetts do not have lifetime limits. The ACA requires that new or existing plans cannot impose lifetime limits on EHBs. Benefits that are not considered EHBs, however, may be subject to limitations.

• **Limits on Consumers’ Out-of-Pocket Costs**: Beginning in 2014, the ACA requires that a group health plan limit a member’s out-of-pocket costs for EHBs. The actual limit amount is tied to what the Internal Revenue Service (IRS) defines as the maximum out-of-pocket cost for a High Deductible Health Plan. For 2013, that amount is $6,350 for an individual and $12,700 for a family. These amounts will be updated annually by the IRS.

Currently, Massachusetts has provisions in its MCC regulations which indicate that if an individual has a health plan with an out-of-pocket maximum of more than $5,000 for an individual or $10,000 for a family, that plan will not meet the state coverage requirements for purposes of the individual mandate. However, as part of the Commonwealth’s efforts to align provisions of state and federal reform, these regulations have been amended such that beginning in 2014 the allowable limits for individuals and families are in line with the ACA requirements.

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5 This does not apply to grandfathered individual plans.
Reforms to Promote Transparency

• Medical Loss Ratio (MLR) Requirements: MLR refers to the percentage of the premium that is used to pay medical claims compared to the total cost of the premium (or the price an individual pays to enroll in insurance). As of 2011, the ACA requires health plans to meet certain MLR targets (85% for large group plans and 80% for small group and individual plans) or to provide rebates to members enrolled in plans that did not meet these targets.

Massachusetts also has MLR requirements in place. The requirements for large groups mirror those in place under the ACA, but the requirement for the merged market (i.e., small group and individual market) is more stringent than the ACA requirement. Specifically, for the small and individual market segment Massachusetts requires an MLR of 90% as of January 1, 2012, 89% as of January 1, 2014, and 88% as of January 1, 2015 and thereafter. Consequently, in Massachusetts, this stricter standard is in place and is used to determine, if applicable, the rebate amounts disseminated to enrollees in plans that do not meet MLR requirements.

• Metallic Tier Requirements: Beginning in 2014, the ACA requires all health plans in the small group and individual markets (both in and outside of the Exchange, or Health Connector) to be offered in a particular metallic tier. These metallic tiers are categorized by an actuarial value (AV), or the share of health care costs the plan covers for a typical group of enrollees. AV also provides a sense of the relative generosity of a plan. So, for example, plans in the Platinum tier, which are required to have an AV of 90% +/- 2, will be more generous than all other plans, considering Gold plans must have an AV of 80% +/- 2%, Silver Plans 70% +/- 2%, and Bronze plans 60% +/- 2%.

Though the Health Connector does currently rely on metallic tiers to help structure its shopping experience for individuals and small businesses, these tiers are not tied to required AVs. Moreover, plans in the small group and individual market offered outside the Health Connector are not organized by metallic tiers. This new requirement in Massachusetts will enable small group and individual shoppers in Massachusetts to have a better sense of the relative value of plans available to them, which should serve as a tool that makes it easier to compare health plans.

• Summary of Benefits Coverage (SBC): All health plans and plan sponsors of self-funded benefit arrangements are now required to provide an SBC to applicants and enrollees in a culturally and linguistically appropriate manner.

The SBC must not exceed four pages in length and must include information related to definitions of insurance terms; a description of the coverage; coverage exceptions, reductions, and limitations; cost-sharing provisions; renewability and continuation of coverage provisions; a coverage facts label that includes examples of common benefit scenarios; a statement of whether the plan provides minimum essential coverage and ensures that the plan covers at least 60% of total allowed costs; and a contact number.
Members must also be notified no later than 60 days before material changes are made to the SBC. The purpose of the SBC is to help applicants and enrollees better understand and compare their health insurance options and the coverage their selected plan provides.

**Reforms to Modify the Rules for Premium Pricing**

The ACA makes a number of changes to the way that the small group and individual health insurance markets work and how health insurance premium prices are set within it. Some of the changes included in the law have already existed in Massachusetts for some time, whereas others are new. As context, in Massachusetts, we have what is called a “merged market” which means that the individual or non-group health insurance market and the small group health insurance market are combined as one risk pool and are generally subject to the same premium rating rules and consumer protections.

**Rating Factor Modifications:** The ACA precludes the use of certain rating factors which are currently allowed for purposes of developing a premium rate in the Massachusetts merged market. The rating factors that are currently used in the state that will no longer be allowable include those that favor groups that have a certain account group size, industry, participation rate, and intermediary and small group purchasing cooperative factors. Changes to these factors may result in premium increases for some individuals and small groups and premium decreases for other individuals and small groups, assuming no change from one’s current plan.

The Patrick Administration has sought to mitigate the likelihood of price disruption in the Massachusetts marketplace. Specifically, Governor Patrick secured a transition period for Massachusetts to phase out those rating factors currently in place in the merged market – rather than have these pricing changes occur overnight. This request will allow the Massachusetts merged market to adjust to these changes over a transition period from 2014 to 2016, smoothing any premium impacts that may occur as a result and preventing market disruption.

**Annual Rate Filings:** National health reform introduces some changes to the “rate filing” requirements for the merged market. Specifically, the law requires carriers to file the rate for their products annually and to keep the premiums for the products the same throughout the calendar year, regardless of an individual’s month of enrollment.

Currently, in Massachusetts, carriers submit quarterly rate filings to the DOI and are able to modify their premiums monthly. As is the case with the above requirement, the DOI was able to acquire a waiver to allow small groups a transition period to come into compliance with this requirement. However, beginning in 2014, for consumers buying non-group health insurance, premium prices will be set annually and will not change on a monthly basis.
Chapter 4: The Massachusetts Health Connector - The Commonwealth’s Online Marketplace

As described in the previous sections, the ACA introduces a host of important changes intended to make it easier for consumers to access affordable and comprehensive coverage. In conjunction with these changes, national health reform also encourages states to establish state-based Marketplaces as one of the primary vehicles to deliver these benefits to consumers. For consumers, these “Marketplaces,” or online websites, are intended to serve as the one-stop shop where individuals can determine if they are eligible for the new programs that help make insurance more affordable and can compare and enroll in health or dental plans.

Massachusetts already has this type of Marketplace, and it is known as the Health Connector. However, the national health reform law will mean changes to the Health Connector such that it will look and feel somewhat different than the Marketplace consumers may have known previously. Generally, the changes that are coming for the Health Connector will mean more choice for consumers (e.g., more participating health plans, dental plans available for purchase), coupled with additional decision support tools and a more consumer-friendly shopping experience.

**Open Enrollment**: The ACA specifies annual Open Enrollment periods, or times during which an individual can enroll in health insurance coverage or change their plan for any reason. The first federal open enrollment period runs from October 1, 2013 through March 31, 2014. During this period, an individual can apply for and enroll in a QHP for coverage that will be effective as soon as January 1, 2014. Specifically, individuals that enroll between October 1 and December 31 may qualify for coverage effective as of January 1, 2014. For individuals that apply and enroll in coverage between January 1 and March 31, their coverage will become effective the first day of the month after the health insurance is purchased. So, for example, if one were to purchase a health insurance plan on January 13, this coverage would become effective – or would begin to pay for the costs of any services covered by the health plan – as of February 1, 2014. The exception to this general rule is in the case where an individual purchases a health plan within fewer than five business days before the end of the month. In that instance, coverage becomes effective the first of the month in the second month following the purchase of the health insurance. To provide an example in this instance, if an individual purchases health insurance as of January 27, 2014 their coverage does not become effective until March 1, 2014. After the first federal Open Enrollment period, all subsequent Open Enrollment periods will run from October 15 – December 7.

Individuals and families can also use the Health Connector’s website to apply for and enroll in MassHealth coverage at any time during the year because the open enrollment rules described above do not apply to MassHealth.

**Qualifying Events and Special Enrollment Periods**: There are certain exceptions that allow an individual or family to enroll in or change health plans outside of these defined open enrollment periods. If an individual or family meets one of the following
special conditions, often referred to as qualifying events, they would be able to buy or change health insurance during a time other than Open Enrollment:

1. Gains a dependent or becomes a dependent as a result of marriage; birth, adoption, or placement for adoption; court-ordered care of a child;
2. Loses coverage for a reason other than failure to pay premiums. This includes loss of coverage due to:
   a. Termination of COBRA continuation coverage.
   b. In the case of an employee or dependent who has coverage that is not COBRA, termination as a result of loss of eligibility (regardless as to whether the individual is eligible for or elects COBRA);
   c. The individual becomes eligible for Medicare;
   d. Legal separation, divorce, or cessation of dependent status;
   e. Death of an employee, termination of employment, reduction in the number of hours of employment;
   f. An individual is no longer residing, living, or working in the issuer’s service area;
   g. An individual incurring a claim that would meet or exceed a lifetime limit on all benefits;
   h. A plan no longer offering any benefits to the class of similarly situated individuals that includes the individual or a plan that was decertified by the Health Connector;
3. Becomes newly eligible or newly ineligible for advance premium tax credits or cost sharing reductions and meets certain other criteria associated with these eligibility changes.

The Application Process and Real-time Eligibility Determination:

Beginning with the Open Enrollment that starts as of October 1, 2013, the Health Connector at MAhealthconnector.org will serve as the Commonwealth’s access point for individuals and families to determine their eligibility for all subsidized health insurance coverage (including MassHealth, ConnectorCare plans, and Health Connector QHPs with tax credits) as well as for unsubsidized QHPs offered by the Health Connector.

To that end, the Health Connector, in collaboration with the Executive Office of Health and Human Services (EOHHS) and UMass Medical School, has developed a new electronic system for eligibility and enrollment with enhanced functionality including real-time eligibility determination. Specifically, the Health Connector will have the capability to assess an individual or a family’s MAGI, as required by the ACA, which will be used to determine eligibility for certain MassHealth populations and for ConnectorCare plans and QHPs with tax credits.

In order to begin the application and eligibility determination process, individuals will

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6 MEC is the level of coverage required to satisfy the federal individual mandate. This is discussed in greater detail on page 25 of this guide.
be asked a series of questions. The type of information and responses individuals will need to provide will include:

- **Name**
- **Address**, including street (no P.O. boxes will be accepted), city, state and zip code
- **Date of Birth**
- **Gender**
- **Social Security Number**, if the individual has one
- **Answers to the following questions:**
  - Do you intend to reside in Massachusetts?
  - Are you a US citizen or national?
  - Are you a natural or derived citizen?
  - Are you incarcerated?
  - Did you age out of foster care at age 18 or older?
  - Are you a member of a federally-recognized or American Indian or Alaskan Native tribe?
- **Other, more detailed questions** may be asked depending on the responses to the questions above. The purpose of this process is to make sure enough is learned about the applicant to determine the best – or most generous – insurance option for which they qualify.

Generally, within minutes, a consumer will be informed as to what programs, if any, they qualify for to help lower the cost of health insurance. After that, they can begin shopping for a health insurance plan that best meets their needs and budget.

**Appeal Rights**: If an individual disagrees with the eligibility determination with respect to: a) their right to purchase through the Health Connector Marketplace, b) their eligibility for certain subsidized programs (e.g., MassHealth, CommCare plans, tax credits), or c) the amount of the tax credit, (s)he has the right to appeal that decision. An appeal can be made following a final decision on eligibility or credit amount, and can occur at the conclusion of the application process, or if eligibility is redetermined during the benefit year or at annual renewal. A consumer may also submit an appeal if (s)he believes the Health Connector failed to provide notice of eligibility determination in a timely way.

When an individual receives a final eligibility decision, (s)he will receive an appeal with information pertaining to the action or decision that can be appealed. The consumer must complete the form and then return it according to the instructions on the form. Initially, appeals will only be able to be submitted in paper form by mail or fax, but eventually appeals will be able to be submitted electronically or telephonically.

When an individual receives a final eligibility decision, (s)he will receive an appeal with information pertaining to the action or decision that can be appealed. The consumer must complete the form and then return it according to the instructions on the form. Initially, appeals will only be able to be submitted in paper form by mail or fax, but eventually appeals will be able to be submitted electronically or telephonically.
the appeal is being considered (this is often referred to as aid pending appeal). In some instances, there will be an opportunity for informal dispute resolution in which the person who has filed the appeal will be called and asked to provide information or documentation before the hearing, in an effort to resolve the issue more quickly. If the individual is satisfied with the result of the informal resolution, (s)he may withdraw the appeal without needing to attend a hearing. If the individual is dissatisfied with the results of the informal resolution, a more formal hearing will be scheduled.

Hearings will be conducted by a hearing officer, either in person or by telephone. After the hearing, the hearing officer will issue a decision with reasons and findings. Individuals dissatisfied with the outcome of an appeal may file an action for review by a judge in the state's Superior Court under Massachusetts General Laws Chapter 30A. Additionally, individuals dissatisfied with the outcome of an appeal regarding eligibility or amount of tax credits may request further review through the U.S. Department of Health and Human Services.

Selecting a Health Plan: Once a consumer is determined eligible to shop through the Health Connector, (s)he can begin the process of comparing health plans and selecting the right plan for enrollment. The eligibility determination process will ensure that an individual's shopping experience is specifically tailored to her/his circumstances; only those plans for which (s)he is eligible will appear. For example, an individual with income above 300% FPL will not be able to view or enroll in a ConnectorCare plan.

As described in the section of this guide on insurance market reforms, health plans available through the Health Connector will be available in certain metallic tiers, Platinum, Gold, Silver, and Bronze, based upon their actuarial value. Health insurance carriers that will be offering plans within these tiers, based on award of the Conditional Seal of Approval in June 2013, will include: Blue Cross Blue Shield of Massachusetts, Boston Medical Center HealthNet Plan, CeltiCare Health Plan, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Minuteman Health, Neighborhood Health Plan, Network Health, and Tufts Health Plan.

In addition to plans within these metallic levels of coverage, some individuals may be eligible for coverage known as “Catastrophic” coverage. Catastrophic coverage options will only be available to individuals who are 30 years of age or under or who are exempt from the individual responsibility requirement (described in more detail on page 25) because of a hardship or the lack of affordable health insurance. Health insurance plans that will be offering Catastrophic plans, based on award of the Conditional Seal of Approval in June 2013, include: Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Minuteman Health, Neighborhood Health Plan, Network Health, and Tufts Health Plan.

While these levels of coverage will be helpful in providing some information with respect

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\(^8\) Catastrophic coverage initially only provides coverage for preventive visits and up to three primary care visits. If other health care services are used, coverage is not provided until the individual has spent the full out of pocket cost allowed by the plan. For 2014, that amount is $6,350 for an individual.
to the relative value of plans, the Health Connector will introduce a host of other tools designed to make it easier for consumers to compare options before making a choice as to the plan that is best for them. For example, within each of the metallic tiers, the Health Connector will offer at least one “standardized” plan design. This means that the Health Connector has described the features or cost sharing of a particular health benefit plan and that all health plans that offer plans through the Health Connector must offer this specific design; the purpose of this is to make it easy for consumers to make “apples-to-apples” comparisons across different health plans.

In addition, the Health Connector’s website will also feature search filters, tutorials, and educational videos. For example, if an individual only wants to see plans without any deductibles, there is a filter tool that will enable her/him to isolate these plans. In addition, the website will include a search feature that will allow consumers to identify only those plans that include a particular doctor or hospital. For someone who needs help understanding health insurance terms, the website features tutorials and educational videos designed to help explain common but nonetheless complicated health insurance terms like deductibles and co-insurance.

**Transitioning Members:** As mentioned in Chapter 2: Programs and Policies to Help Pay For Health Insurance, implementation of national health reform will mean changes to the programs available to help people pay for health insurance.

As described above, people who are currently enrolled in the Health Connector’s Commonwealth Care program and have incomes of up to 138% FPL (or about $16,000 for a household of one) will become eligible for MassHealth. In addition, other people enrolled in the Commonwealth Care program will become eligible for ConnectorCare plans, which have a new name, but are designed to provide members with benefits and costs that are similar to what they experience today in Commonwealth Care. Specifically, individuals enrolled in ConnectorCare plans will receive federal tax credits, but the state will also help pay for premiums and cost sharing reductions so these plans feel similar to Commonwealth Care. Certain people eligible for ConnectorCare programs will also be eligible for cost sharing reductions.

Members of MSP, administered by DUA for residents currently receiving health insurance assistance while receiving unemployment benefits, will also be experiencing changes to the health insurance options available to them. Many current MSP members will become eligible either for MassHealth or for premium tax credits through the Health Connector. Some residents who have relied on the state’s Health Safety Net (HSN) may also find that the changes brought about by national health reform provide a new option to help them pay for health insurance coverage; for example, residents with income between 300-400% FPL who were previously not eligible for Commonwealth Care may well be eligible for premium tax credits through the Health Connector. Finally, some individuals who are enrolled in certain MassHealth programs such as Basic, Essential and the IP will also experience changes in their coverage.
The Health Connector, in collaboration with MassHealth, has developed an extensive member transition plan that will make the shift to 2014 as smooth and seamless as possible. As noted previously, most members who qualify for new MassHealth programs in 2014 will be transitioned automatically and will not need to take action. This includes eligible individuals currently enrolled in Commonwealth Care, MassHealth Basic, MassHealth Essential and IP, as well as individuals receiving services paid for through the HSN. MassHealth will conduct outreach in the fall of 2013 to let members know about the coming changes in their coverage and the changes will be effective on January 1.

Those individuals who may qualify for coverage through the Health Connector in 2014, as well as all MSP members, will need to take action to apply for the new subsidies and enroll in insurance. The Health Connector is implementing an extensive direct outreach strategy, in an effort to reach more than 215,000 current and newly eligible Health Connector members who will be transitioning to new coverage models available beginning in 2014. This outreach effort will be multi-faceted and will run from October 1, 2013 through March 31, 2014 in line with the initial federal Open Enrollment. This outreach effort will include a comprehensive outbound calling campaign targeting existing Health Connector enrollees, including Commonwealth Care, Commonwealth Choice and Business Express members, as well as individuals transitioning from other insurance programs such as the IP and MSP, and uninsured individuals receiving services through the HSN. Finally, it will also include those individuals who have been identified as previously eligible for Commonwealth Care but who have never enrolled.

In addition to the outbound calling campaign, the Health Connector will also be employing a direct mail strategy. This will mean including information about new programs and benefits and the need to actively transition to new programs in materials disseminated to existing members as well as generating new postcards, and open enrollment packets highlighting new plan options and a call to action with a “Return to Us” letter explaining an individual must respond in order to enroll in new coverage and avoid any gaps in health insurance coverage.

These efforts will complement other marketing, outreach, and education efforts launched by the Health Connector, MassHealth and other partners in an effort to generate awareness about implementation of national health reform. The Health Connector will actively engage with other stakeholders to solicit their review of associated outreach materials and to keep them apprised of these activities. In particular, the Health Connector will work to ensure Navigators, Certified Application Counselors (CACs) and other consumer assisters are aware of the timing and content of distribution materials so these partners are best equipped to help members respond accordingly.
Chapter 5: Shared Responsibility

As described in the introduction to this guide, a cornerstone of both the state and national health reform laws is the concept of shared responsibility. While the government assumed responsibility under both state and national health reform initiatives to aid in making health insurance more affordable and more accessible to individuals (i.e., through the establishment of state-based Marketplaces that serve as the distribution channel for subsidies for those who qualify and that otherwise make it easier for consumers to find health insurance options), both laws also included provisions intended to encourage employers to offer coverage and individuals to become enrolled and remain enrolled in health insurance coverage. These provisions foster the environment and provide the options that make it possible to encourage – or require - personal responsibility for acquisition of health insurance. Together, these components are designed to make the goal of providing everyone access to affordable health insurance coverage achievable. As part of our national health reform implementation efforts, we have also looked closely at existing state policies associated with employer responsibility and individual responsibility with an eye toward ensuring that state and national policies will work seamlessly and effectively together in a way that best serves Massachusetts employers and consumers.

Incentives for Employers to Offer Health Insurance:
As part of Massachusetts’ landmark health reform law passed in 2006, known as Chapter 58 of the Acts of 2006: An Act Providing Access to Affordable, Quality, Accountable Health Care, there were several new policies introduced to encourage employers to offer health insurance. These included: the Fair Share Contribution (FSC), Health Insurance Responsibility Disclosure (HIRD) requirements, the requirement to provide employees with the ability to create plans under Section 125 of the Internal Revenue code to pay for health insurance, and the Free Rider Surcharge for employers who do not meet the Section 125 requirement.9 Beyond just quickly meeting these new requirements (which the vast majority of employers did), Massachusetts employers stepped up to meet the spirit of the law, as well. Massachusetts employers maintained and even increased their rates of offering health insurance to their workers, outpacing their national peers. In response, particularly in the years immediately following implementation of reform, more consumers got health insurance from their employers.

As is described below, national health reform also included several employer-related provisions. While Massachusetts certainly served as an example of the success in implementing reform built on the concept of shared responsibility, the technical details of the two laws do differ. To that end, the passage and implementation of national health reform has provided Massachusetts with a unique opportunity to take a fresh look at its own state-level health reform policies to ensure that we streamline requirements where possible, only keeping the policies that remain truly necessary and provide a substantial public benefit. In line with this objective, certain state-level policies have been altered in the spirit of simplification and efficiency. These changes are described in more detail in the Massachusetts Employer’s Comprehensive Guide to National Health Reform.

9 Each of these policies is explained in more detail in the companion Employer Guide to the ACA.
There are a few key provisions in the national health reform law that are intended to encourage employers to offer health insurance. In particular, national health reform provides small businesses that meet certain criteria with the opportunity to qualify for federal tax credits when they purchase health insurance through the Health Connector. In addition, it establishes potential penalties for large employers not offering coverage or offering coverage that isn’t affordable or of sufficient value. These are described in more detail below.

- **Small Business Tax Credits:** Small businesses with fewer than 25 employees earning average annual wages below $50,000 may be eligible for federal tax credits of up to 50% when they purchase health insurance through the Health Connector. This tax credit is only available to small businesses that purchase group coverage through Marketplaces (in Massachusetts, the Health Connector).

- **Possible Penalties for Large Employers:** Large employers may face a federal assessment or penalty for not offering coverage, or offering coverage that is not considered affordable or of sufficient value to full-time employees.

Specifically, employers with 50 or more full-time equivalent employees (FTEs) may be subject to a federal assessment if any of their full-time employees qualify for and receive premium tax credits to purchase health insurance through a Marketplace (in Massachusetts, the Health Connector). The eligibility criteria for these tax credits are described on page 8. This provision of the ACA was originally scheduled to become effective as of January 1, 2014, but the US Treasury announced in July 2013 that implementation would be postponed until January 1, 2015 in order to allow employers additional time to come into compliance.

To aid in the implementation of this provision, if a consumer/employee qualifies for and enrolls in coverage with a premium tax credit through the Health Connector, the Health Connector - as the state’s Marketplace - is required to send the employer a notice indicating this has happened so that the employer is aware it may be subject to a penalty.

However, it is important to note that there are numerous circumstances in which a consumer/employee receiving a tax credit will have no bearing on any possible assessment to the employer. For example, a consumer/employee who works for a small employer (i.e., an employer with fewer than 50 FTEs), may qualify for a premium tax credit, and subsequently enroll in a QHP through the Health Connector, prompting a notice to be sent to her/his employer. It is also possible that a consumer/employee who works part-time might may qualify for a premium tax credit and enroll in a QHP through the Health Connector, also prompting a notice to be sent to her/his employer. However, in both of these examples, the consumer’s use of the tax credit would not trigger a penalty for the consumer’s employer. In the first example, the fact that the employer is a small employer means he is not subject to the penalty and in the second example, although the employer is a large employer potentially subject to a penalty, the penalty is only triggered when full-time employees are eligible and utilize the premium tax credit. Marketplaces like the Health Connector are required by law to provide these notices,
but it is important for consumers/employees to understand that they are for informational purposes only, and do not mean that an assessment has been issued. Moreover, regardless of whether a consumer/employee accessing a premium tax credit serves as the trigger for his/her employer being subject to a penalty, an employee/consumer cannot be the subject of discrimination or adverse action by an employer as a result of this circumstance.

**Requirements for Individuals to Obtain and Maintain Coverage**

Perhaps one of the most well known components of the state’s landmark health reform law is the individual mandate, which requires all adults in the state with access to affordable health insurance to purchase it, thereby encouraging personal responsibility and getting as many of our residents as possible covered.

There are three main parts that comprise the Commonwealth’s individual mandate. These include the following:

- **An affordability schedule**: This defines the maximum amount that an individual, couple, or family is required to contribute to health insurance each month. The schedule in Massachusetts is updated each year and has been designed such that it is progressive (i.e., how much one can afford increases as income increases), designating monthly maximum dollar contribution based on your income and family situation (e.g., individual, couple, family) that ought to be spent on health insurance.\(^{10}\) If health insurance that meets the state’s Minimum Creditable Coverage standards (described in more detail immediately below) is not available to a consumer at or below this maximum monthly premium price, (s)he is exempt from the mandate on affordability grounds.\(^{11}\)

- **Minimum Creditable Coverage (MCC) standards**: These regulations define the level or value of health insurance an individual must have in order to satisfy the mandate. The purpose of these regulations is to ensure that individuals have robust coverage that provides sufficient consumer protections. Health insurance carriers licensed in Massachusetts are required to let members know if their plan meets these standards.

- **Penalties**: Penalties are imposed on adult residents for each month of the year in which they fail to acquire affordable health insurance that was available to them. These penalties are set by the Department of Revenue each year and collected at tax time.\(^{12}\) The penalty schedule is also progressive, imposing greater penalties as one’s income increases.

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\(^{10}\) The individuals, couples, and families affordability schedules correspond to the following tax-filing statuses: (Individual or Married Filing Separately; Married Filing Jointly with No Dependents or Head of Household/Married Filing Separately with one Dependent; Married Filing Jointly with one or more dependents or Head of Household/Married Filing Separately with two or more dependents.

\(^{11}\) Please note that there are other circumstances that enable someone to seek an exemption from the mandate or to appeal a penalty. These include, for example, religious exemptions, hardship exemptions.

\(^{12}\) The actual penalty amounts cannot be greater than one half the cost of the lowest cost health plan available through the Health Connector; this methodology was specified in statute.
Since the initial implementation of this requirement in 2007 through the tax filing process, over 99% of taxfilers who were required to complete the component of their taxes pertaining to the individual mandate (i.e., the Schedule-HC) did so. Moreover, analysis of taxfiler data since implementation of this requirement reinforces other state and national surveys suggesting the high insurance coverage rates among Massachusetts residents.

Building on the success of the Commonwealth’s experience with an individual mandate, a cornerstone of the ACA was also an individual mandate to obtain and maintain health insurance. Just as is the case with respect to many of the employer-related policies included in the state and national health reform laws, the technical details of the individual mandate policies at the state and national level do have some important distinctions. However, the Commonwealth has compared these policies and adjusted existing policies pertaining to the state level mandate in an effort to ensure the mandates will work together as seamlessly as possible. It is important to remember that virtually all of Massachusetts’s residents meet the state mandate requirement and have comprehensive health insurance that meets the state’s coverage standards; indeed, in almost all instances, this coverage will also satisfy the national mandate requirement.

Nonetheless, highlighted below are some of the key components of the ACA’s individual mandate provision and a brief discussion of the ways in which these components differ from their associated provisions at the state level. It is important to note that individuals in the Commonwealth are subject to two mandates, however, in most instances, if an individual satisfies the state mandate requirement they will likely satisfy the federal requirement.

• **An Affordability Standard:** The federal individual mandate requires all adults and children to obtain and maintain health insurance so long as it is available to them at a price that is 8% of their income or less. This standard is different than the current state standard, which – as described above, relies on a more progressive approach for calculating an individual’s required contribution for insurance. From a practical perspective, the implementation of this standard in the Commonwealth means that some residents, particularly those with lower incomes, may be required to pay more toward health insurance relative to what the state affordability standard currently requires in order to avoid a potential federal penalty.

Implementation of the federal affordability standard has also prompted some revisions to the state affordability schedule. These changes mean that individuals at middle and upper income levels will now have a cap on the percentage of income they are required to spend on health insurance (10% beginning in 2013 and 8% in 2014) under the state affordability schedule, rather than defining any insurance contribution as affordable for this population.

• **Minimum Essential Coverage (MEC) standards:** While the state reform includes specific regulations defining the characteristics of a health insurance plan that an individual must have in order to satisfy the state’s individual mandate requirement, the ACA specifies broad categories of coverage that constitute MEC. These broad categories of coverage include:
− Any plan provided by the government (e.g., Medicare, Medicaid, CHIP, Tricare, etc.);
− Any plan provided by an employer;
− Any plan purchased in the individual/non-group market (i.e., directly by an individual from an insurance company or Marketplace); and
− Any plan considered a “grandfathered” plan.\(^{13}\)

Coupled with this broad definition of the types of coverage that will satisfy the federal mandate, as described above in the section on insurance market reforms, the ACA introduces a host of changes through direct regulation of the insurance market that are intended to improve the level or value of health insurance coverage that is available to people. However, not all of these changes apply to all the categories of coverage. For example, the EHB requirements are only applicable to plans that are available through a small employer or purchased directly by an individual from a carrier or through a Marketplace.

This circumstance is one of the primary reasons the Commonwealth has opted to retain its own individual mandate. The MEC standards needed to satisfy the federal law are not as robust as in the Commonwealth (i.e., they do not necessarily require individuals to have as high value insurance as the state’s MCC standards require), and this is largely because many of the insurance market reforms introduced by the ACA are only applicable to the small and non-group insurance markets. Maintenance of the state individual mandate means the state’s MCC standards are also retained. This provides the benefit of ensuring protections for consumers regardless of the market in which they acquire their health insurance coverage and mitigating potential inequities between small and large employers.

In line with the efforts to continuously evaluate state policy and regulations and to ensure simplicity and seamlessness with federal rules wherever possible, there have been modest adjustments made to the current state MCC regulations. Since virtually all of Massachusetts’ residents have comprehensive health insurance now, there will be very few instances in which people will face the prospect of a penalty under current state law or the federal law beginning in 2014.

• **Penalties:** Just as at the state level, the enforcement provision of the federal individual mandate is a penalty implemented at tax time. However, the details pertaining to how a federal penalty is calculated and to whom it applies do differ from the state penalty. The federal penalty will be increased over time, but beginning in 2014, a taxfiler who had affordable insurance and failed to acquire it will be subject to a penalty that is the greater of:
  − $95 per adult, or
  − 1% of income over tax filing threshold.

(Please note: the penalty for children or dependents under 18 will be one half the penalty amount for an adult.)

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\(^{13}\)A grandfathered health plan is a health plan that was in effect prior to passage of the Affordable Care Act in March 2010. There are certain rules in place which dictate requirements a plan must meet – in terms of the limited number of changes that can be made to it – in order for a plan to remain a grandfathered plan.
The Commonwealth has carefully considered the implications for consumers of two mandates and two potential penalties. As described above, one of the primary policy reasons for maintaining the state individual mandate is to ensure that consumers continue to benefit from the high coverage standards and high value insurance that has characterized the Massachusetts insurance landscape. Moreover, experience to date suggests that the vast majority of Massachusetts residents have health insurance that will continue to meet the state standard and will also meet the federal standard when it is implemented in 2014.

Nonetheless, there are some instances where it is foreseeable that an individual could be subject to two penalties or be subject to a penalty by either the state or the federal government, but not both. Consequently, the Commonwealth has developed an approach intended to ensure these two penalty structures operate together in a way that is as simple and as minimally burdensome as is possible for Massachusetts residents. Specifically, the approach is intended to avoid any “penalty stacking” (i.e., aggregation of both the state and federal penalties) for consumers.

In order to effectuate this principle, the state’s Department of Revenue plans to institute a “credit approach” in instances where a Massachusetts resident is liable for both a federal and state penalty. Again, it is important to note that the population projected to be in this circumstance is likely very small. Nonetheless, in the circumstance where a Massachusetts tax-filer is subject to both a state and a federal penalty, the resident’s state penalty would be net of any federal liability for failure to comply with the mandate requirement. If the federal penalty is greater than that which the resident would owe under the state penalty rules, the state penalty would be reduced to zero. Alternatively, if the federal penalty is less than that required under the state methodology, the individual would subtract the federal penalty from the state amount and pay the remaining balance to the state. For example, if a middle income (income above 300% FPL or $34,477) adult (over age 26) owes a federal penalty of $260 and a state penalty of $1,272, he/she would pay the $260 penalty to the federal government. She/he would then be liable for $1,012 to the state.
Chapter 6: Resources to Provide the Help or Information You Need - Consumer Assistance and Support

The Health Connector will be partnering with Navigators, Certified Application Councilors (CACs), brokers and other key stakeholders to conduct outreach and education as they simultaneously enroll individuals and small businesses in our programs. In addition, the Health Connector will also continue to provide direct support to individuals and small businesses through our contact center, Public Information Unit (PIU) and our website, MAhealthconnector.org.

Navigators: A core feature of outreach and enrollment efforts under the ACA is the Navigator program. All states, even those for which the federally-facilitated Marketplace will operate, must establish Navigator programs to help consumers understand new coverage options available as a result of the ACA and find the most affordable coverage that meets their needs.

The Health Connector has designed a unique Navigator program focused on the specific needs of Massachusetts. While in nearly all other states the outreach work of Navigators is focused on getting consumers enrolled in coverage for the first time, in Massachusetts a crucial priority is the transition of residents that are already insured to the new coverage programs that become available as of January 1, 2014. To that end, those entities serving as Navigators have been charged with ensuring, in close collaboration with the Health Connector and MassHealth, end-to-end support for transitioning members. In addition, Navigators are expected to target the remaining uninsured and to aid them in identifying and enrolling in insurance options for which they are eligible.

There are ten community organizations currently serving as Navigators. These organizations include:

- Boston Public Health Commission
- Caring Health Center
- Community Action Committee of Cape Cod & Islands, Inc.
- Ecu-Health Care
- Greater Lawrence Community Action Council
- Hilltown Community Health Care Centers
- Joint Committee for Children’s Health Care in Everett
- Manet Community Health Center
- MAPS – Massachusetts Alliance of Portuguese Speakers
- PACE - People Acting in Community Endeavor

These organizations have been trained by the Health Connector to ensure robust knowledge of new programs, benefits, and systems so that they are readily able to assist consumers. In their role as Navigators, these entities will be hosting frequent (at least three per month) outreach and education events, distributions collateral and other educational materials in multiple languages, facilitating enrollment beginning in October and targeting transitioning populations during the first half of open enrollment. In addition, when a Navigator identifies consumers for whom they cannot provide appropriate assistance, the Navigator will refer the consumer to another organization or a broker that is better equipped to handle the consumer’s particular needs.
**Certified Application Counselors (CACs):** All state-based Marketplaces, like the Health Connector, are required to have a CAC program. CAC organizations are generally community health centers or other health care provider organizations, hospitals, or social service agencies. These organizations and the staff or volunteers they employ are intended to help people understand the benefits and programs that might be available to them and to enroll them in the appropriate coverage option available to them. CAC organizations must ensure that the CACs providing direct assistance to individuals have completed necessary training and that they adhere to necessary privacy and security laws so as to ensure adequate protections are in place for the consumers to whom they are providing assistance. State based Marketplaces are responsible for ensuring training and certification of the CAC organizations.

Massachusetts has a longstanding history of provider collaboration and has benefitted greatly from the work of community providers in facilitating enrollment into health insurance coverage. This experience will be leveraged in establishing the CAC program. The Health Connector and EOHHS will be targeting current Virtual Gateway providers as CAC organizations. As part of this effort, the Health Connector and EOHHS will work closely with the Massachusetts Hospital Association (MHA) and the Massachusetts League of Community Health Centers to identify the best approaches for providing initial and ongoing training to interested CAC organizations. This training and certification is being implemented in phases, beginning in September in preparation for October 1, and continuing throughout the fall. The expectation is that all qualifying Virtual Gateway organizations wishing to become CACs will be designated as such prior to January 1, 2014. To aid consumers in identifying organizations in their area that might be able to assist them at the point of service, a list of the current Virtual Gateway providers who have completed training and been certified as CACs will be posted on MAhealthconnector.org.

**Brokers:** The Health Connector recognizes the important role that brokers play in providing information to individuals and small businesses and in facilitating enrollment in health insurance. To that end, we will continue to provide training to brokers on the implications of national health reform for consumers and small businesses in the Commonwealth. This will be provided through Continuing Education (CE) courses, Broker Advisory Council workgroups and meetings, as well as continual correspondence and dissemination of educational collateral through the Health Connector’s Broker Newsletter. Part of our efforts will ensure brokers are sufficiently informed of the work of selected Navigators so the work of these important partners can be appropriately collaborative and complementary.

**Health Connector Contact Center, Website, and Public Information Unit:** In addition to the services provided by these important outreach and education partners, the Health Connector will also provide direct consumer support through a host of different channels including the contact center, the MAhealthconnector.org website, and the PIU. The Health Connector’s contact center can be reached at 1.877.MA.ENROLL (1-877-623-6765) and will generally be open from 8 a.m. to 6 p.m. Monday through Friday. During the Open Enrollment period from October 1, 2013 – March 31, 2014, it will provide extended hours of service. This means that during this time the contact center will be open from 7 a.m. to 7 p.m. Mondays through Friday and from 9 a.m. to 3 p.m. on Saturdays. The contact center is able to provide member support in a number of different languages. Members are always able to access MAhealthconnector.org for up-to-date information. In time, through this website, the Health Connector will also provide online chat support and a message center in an effort to further aid consumers.
The PIU provided instrumental information and assistance during the 2006 launch of state health reform. As Massachusetts consumers, employers, and other interested parties had more experience with the state’s health reform initiative, the volume of inquiries to the PIU was gradually reduced, but the role of the PIU has always been an important component of the Health Connector’s outreach and education efforts. Mindful of the likely resurgence of inquiries spurred by implementation of national health reform and the changes brought about by this sweeping law, the Health Connector is buttressing its PIU to serve as a centralized unit (comprised of 2-3 staff members) to provide assistance to the general public, legislature, other state offices and federal agencies. The PIU will work closely with the Health Connector’s Contact Center. In order to contact the Health Connector’s PIU, consumer’s may call 1.877.MA.ENROLL (1-877-623-6765) and follow the prompts for the PIU.
Appendix: For More Information

There are many websites and resources available that can provide additional detail on the policies described in this guide.

The Massachusetts Health Connector (Massachusetts’s Health Insurance Marketplace)
• Website for Massachusetts Health Connector (Massachusetts’s health insurance Marketplace) to find information on health insurance coverage options, subsidy eligibility determinations, as well as policy information for employers, individuals/families, researchers, and the public: MHealthconnector.org

MassHealth
• Website for MassHealth, the Massachusetts Medicaid and CHIP programs to find information on eligibility and benefits for MassHealth programs. MassHealth has a web page dedicated to providing information about the ACA for current members and applicants: mass.gov/eohhs/provider/insurance/masshealth/aca/information-for-masshealth-members-applicants-and-aca

Information on Massachusetts Affordable Care Act implementation
• Website with information on state implementation activities including stakeholder meeting materials, grant awards, comment letters in response to federal regulations, and weekly updates on ACA guidance and news, as well as the opportunity to sign up to receive the weekly updates by email. mass.gov/nationalhealthreform

Federal Sources of Information:
• National Health Reform Website: healthcare.gov
• The Center for Consumer Information and Insurance Oversight: cciio.cms.gov/

Other Sources of ACA Information:
• National Association of Insurance Commissioners and Center for Insurance Policy and Research: http://www.naic.org/index_health_reform_section.htm
• Henry J. Kaiser Family Foundation: http://kff.org/
• National Academy for State Health Policy: http://www.nashp.org/aca-implementation-state-health-reform-0
• Health Care for All: http://www.hcfama.org/
• Blue Cross Blue Shield Foundation of Massachusetts: bluecrossmafoundation.org
Appendix: Common Scenarios and Questions

1) I am currently on MassHealth. Will anything change? Who will be newly covered by MassHealth?

Individuals currently on MassHealth will generally stay on MassHealth, and additional categories of individuals will become eligible. Childless adults with income up to 138% of Federal Poverty Level (FPL) will be eligible for coverage beginning January 1, 2014. For a single individual, this is $15,856 in 2013. Also newly eligible are 19 and 20 year olds who earn up to 150% of FPL, or $17,235.

Certain MassHealth programs, such as MassHealth Basic and Essential, are ending and members currently eligible for these programs will instead qualify for more benefits through MassHealth Standard or a new benefit plan called MassHealth CarePlus. MassHealth will send letters in November to any members whose coverage is changing to let them know about the coming changes and if there is anything they need to do. Some members may need to select a new health plan.

2) I am currently on Commonwealth Care and have been informed that program is ending on January 1, 2014. Will I still have coverage? If so, how do I find it and get enrolled? Will I have to pay more, and will I have the same plans available?

Most Commonwealth Care enrollees will continue to qualify for subsidized coverage in 2014. Many of them will be transitioned to MassHealth programs. Others will have to apply to find out how much federal premium tax credit and additional state subsidies they could receive. Plans and premiums will be very similar to current Commonwealth Care offerings.

Current members should watch their mail for personalized information about the upcoming changes. General information will be available on our website, MAhealthconnector.org.

3) I am single and I work part-time at my job, earning $20,000 a year. My job provides health insurance and the premium contribution is $400/month or $4,800 a year. I can’t afford this. Will I get penalized for not buying it? Is there any way for me to buy through the Health Connector? If so, when?

At $4,800 per year, the health insurance available to you is not considered affordable to you based on both the state affordability schedule in effect as of calendar year 2013 (which specifies affordability as no more than $40 per month or $480 per year towards a health insurance premium for someone with your income) and the federal affordability standard (which defines affordability as 8% of income or less, or $1,600 a year or $133 per month toward a health insurance premium). Consequently, you will not be penalized for not buying this insurance.

It is likely, based on your income, that you would qualify for premium tax credits or even a ConnectorCare plan through the Health Connector. (Please note as described above on page 8, there are other eligibility criteria for premium tax credits.) It is possible to begin enrolling in coverage effective as of January 1, 2014 as early as October 1, 2013 by visiting our website, MAhealthconnector.org.
4) I am single and I work full-time at my job, earning $40,000 a year. My job provides health insurance and required a premium contribution of $70 every two weeks (or $1,820 per year). I can’t afford this. Will I get penalized for not buying it? Is there any way for me to buy through the Health Connector? If so, when?

At $1,820 per year, the health insurance available to you is considered affordable based on both the state affordability schedule in effect as of calendar year 2013 (which specifies affordability as no more than $2,136 per year or $178 per month towards a health insurance premium for someone with your income) and the federal affordability standard (which defines affordability as 8% of income or less, or $3,200 a year or $267 per month toward a health insurance premium). Consequently, you will be penalized for not buying this insurance.

Since this coverage provided by your employer is considered affordable under the federal law, you will not qualify for help paying for health insurance when shopping through the Health Connector.

5) My child just has a new job, but I am not sure yet if it will offer her health insurance. Can I keep her on my family plan, and if so to what age? What would disqualify her from staying on my family plan? For example, does she have to remain a student?

Your daughter can stay on your family plan until age 26, even if she is not a student. In fact, she can be covered under your plan even if she gets married or is living apart from you. However, some employers (who have grandfathered plans) may not allow young adults if they have access to their own employer-sponsored insurance.

6) I am a single mother and I earn $32,570 per year. I do not have access to employer sponsored health insurance. I am looking for health insurance for me and my five year old son. What options are available to me?

At this income level (210% FPL), your son is likely eligible for MassHealth Family Assistance. This program provides health insurance to children under 19 in families with income under 300% FPL. You will likely qualify for a ConnectorCare plan through the Health Connector. (Please note as described above on page 8, there are other eligibility criteria – beyond income - for premium tax credits and ConnectorCare plans.)

7) I work full-time and earn $27,900. I do not have access to employer sponsored insurance through my job and my husband is disabled. We are looking for health insurance that will cover the two of us. What options are available to us?

At this income level (180% FPL), your husband may qualify for CommonHealth based on his disability. You will likely qualify for a ConnectorCare plan through the Health Connector. (Please note as described above on page 8, there are other eligibility criteria – beyond income - for premium tax credits and ConnectorCare plans.)